A review of the effect of occupational experience of patient death and death situations on Nurses

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Abstract

Background: Impacts of regular occupational exposure and experience of patient death on nurses' professional quality of life and well-being. Despite the impacts, it has not yet been adequately addressed by professional training, research and by employers of nurses. **Purpose:** To analyze the impacts of occupational exposure, experience of patient death and death situations on nurses' professional quality of life and recommend strategies to curtail them. **Methods:** Studies were retrieved from three databases CINAHL, SCOPUS, MEDLINE and reference lists of relevant journal publications. **Results:** The findings show that the impact of experience of patient death on nurses positively or negatively depending on the way patient death is perceived (good or bad). The positive outcomes include increased professionalism, devotion to patient care, bonding with deceased patient's family members and individualized patient care. The negative impact may be short-term emotional reactions such as fear, severe grief, and self-doubt. The short-term adverse outcomes can initiate long-term consequences such as compassionate fatigue, burnout, and withdrawal from practice among nurses with inappropriate coping. **Conclusion:** Occupational exposure to death situations can adversely influence patient care and nurse's professional quality of life. Nurse educators, employers, and researchers should play a proactive role in enhancing nurse's knowledge, skills, and coping.

Keywords: death, emotional support, grief, nurses, occupational exposure, professional quality of life

Introduction

Patient death and occupational exposure to death are the existing realities for nurses in spite of increasing technology in advanced health systems, longer patient survival, and cure rates from previously fatal conditions (Lehto & Stein, 2009). The growing availability of palliative care services for dying persons and their families, has not yet reduced the percentage of human deaths occurring in healthcare facilities such as hospitals under the care of nurses without specialized training in hospice or palliative care (Ellershaw, Dewar & Murphy, 2010; Gomes, Calanzani & Higginson, 2011). The majority of

human death still do occur in medical facilities that are away from the public gaze (Muir, 2002), and this translates into regular encounters with patient death and associated situations by nurses.

In addition to increasing occupational exposure and experience of death, exclusion of death from ordinary daily life into the sanitized hospital settings has in a way created a mystique which exacerbates anxiety and other emotional reactions associated with patient death among nurses (Bryan, 2007). This may be one of the reasons why death is often regarded as a failure of medical and nursing care, and a source of guilt feelings by nurses and other health care professionals (Huang, Chang, Sun & Ma, 2009). As a result in clinical settings such as hospitals where the purpose is to sustain life and not to ease death, there is much reluctance to speak about death (Yu & Chan, 2010). The unwillingness to discuss about death comes from health care professionals in general, and not patients or their families (Rabow,

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Schanche, Petersen, Dibble & McPhee, 2003). On the part of nurses, the reluctance may be because of the close relationships they establish with patients and their relatives. The death of patients is something nurses do not enjoy experiencing because it elicits feelings of anxiety and discomfort when it occurs (Bryan, 2007; Polat, Alemdar & Gürol, 2013).

The other reason for the reluctance to talk about death may be the lack of knowledge and skills to handle death situations. Literature shows that many nurses in practice did not receive specific training or preparation in dealing with death (Bloomer, Morphet, O'Connor, Lee & Griffiths, 2013; Ellershaw et al., 2010). The deficiencies in knowledge and skills related to death and dying, do not only increase anxiety levels and emotional discomfort (Polat et al., 2013), but also make nurses unable to effectively cope with their own feelings and care for others in situations of patient death. The impact of occupational exposure and experience of mortality on nurses, patient relatives, and nursing care is the reason behind the voices which are increasingly calling for training of all nurses in caring and management of death and dying patients and their families (Ellershaw et al., 2010; Polat et al., 2013).

The other benefit of increasing nurse's knowledge and skills related to occupational exposure and experience of death is an enhancement of self-care abilities and coping. Literature shows that observing death and the quality of death seen, affects the level of anxiety experienced by the nurse (Bryan, 2007). Although nurses perceive patient death in different ways (terrible, satisfying, or mixed emotions)- (Smith, 2009), there are particular deaths and death situations that tend to have a negative impact on nurses. For instance deaths that take place in the pediatric units and obstetric wards, are correctly reported to be traumatic to nurses because of their unexpected nature (Smith, 2009; Taubman-Ben-Ari & Weintroub, 2008). However regardless of where death takes place or how the nurses feel and react to death of a patient, when it occurs, they are expected to help and comfort the family members and to continue caring for the other patients at the same time (Smith, 2009). Indeed, during death situations, most nurses never get time to stop and think about the meaning of it all (Borsche, 2007). The integration of role expectations, lack of time

to deliberate about death of a particular patient, and lack of training on how to deal with death or family members of a dead patient, can generate inner conflict and stress in the nurse's mind (Gerow et al., 2010). The generated internal conflicts and stress are mostly not immediately resolved, because when death occurs, nurses are expected to remain stable and give support, whether affected or not affected by the death of a person whom they were caring for (Bloomer et al., 2013).

Nurses respond to this occupational exposure and experience of death and associated role expectations by finding ways to cope and sometimes they use ineffective methods such as avoidance and separation of the experience that can result in exhaustion and other physical and emotional problems as opposed to healthy grieving (Hinderer, 2012; Peterson et al., 2010). Literature shows that some nurses judge the death of a patient in isolation from the dying process as a way of avoiding to think about the actual death (Costello, 2006). This way of coping is likely to be ineffective because situations associated with dying patients such as intense treatment, empathy and emotional involvement with a dying patient, can cause more stress and anxiety with the individual patient's suffering or collective trauma, and subsequently secondary traumatic stress disorder (Shimoinaba, O'Connor, Lee & Greaves, 2009). Failure to acknowledge and deal with the emotions that arise from experiencing patient death is also associated with other symptoms of post-traumatic stress disorder (PTSD) such as invasive memories, confusion, lack of attentiveness, addictions, and minimal care for other patients through decreased interactions (Taubman-Ben-Ari & Weintroub, 2008). Therefore, nurse's ineffective coping with occupational exposure and experience of death can adversely affect patient care (Steinhauser et al., 2000). Nurses who do not engage in health grieving or use inefficient methods to cope with death situations can also experience burnout (Shimoinaba et al., 2009).

Besides the emotional and psychological impact, occupational exposure to death and death situations can also lead to physical ill-health and withdrawal from clinical practice, both of which subsequently can lead to high turnover, decreased patient service and satisfaction (Brunelli, 2005). Physical ill-health may be present in form of somatization such as

medically unexplained pain, fibromyalgia, irritable bowel, and chronic fatigue, all which have an active relationship with PTSD (Adreski, Chilcoat & Breslau, 1998). Therefore, occupational exposure and experience of death can significantly impact nurse's professional quality of life and well-being. There is need for all nurses and managers of nursing human resources to have a clear understanding of the effects of occupational exposure and experience of death in order to initiate relevant studies; facilitate effective support mechanisms; enhance quality of nursing care; promote healthy work environment and nurses' professional quality of life.

Objective

The aim of this review was to analyze the impact of occupational exposure and experience of death on nursing care and nurses' professional quality of life and to recommend strategies to curtail its effect.

Methods

Search strategy

The authors formulated a plan to search individual literature and get articles from databases known to have the most recent publications relevant to occupational exposure and experience of death and nurses. The articles were retrieved from databases such as SCOPUS, CINAHL, and MEDLINE and reference lists of journal articles published in the period January 2005-2015. The cut-off date for the literature search was limited to 2005-2015 because this time gives recent articles that discuss recent research and likely to address recent changes in clinical and administrative practices, death rates and therefore nurses' exposure to patient death.

To conduct the literature review we used the following MeSH terms: 1-[nurses], 2-[nurses grief and patient death], 3-[Health outcomes], 4-[emotional support and patient death], and 5-[Well-being]. The search terms were finalized after searches were carried out to exploit the number of citations in the past ten years available to the authors. The search terms were purposely kept broad to avoid losing possibly important publications. A secondary search involved skimming the reference lists of articles selected during the main search. Both search approaches were limited to articles written in English language and reporting

about major qualitative studies. The search yielded 71 articles in MEDLINE, 43 articles in SCOPUS, 34 articles in CINHAL, and four articles from reference lists of journal publications.

For an item to be added in this review, it had to be reporting about a primary qualitative study, focusing on nurses and occupational exposure and experience of death and written in the English language. Qualitative studies were chosen because there is little empirical knowledge about this topic and, therefore, the authors' aim was to find articles providing detailed and diverse findings about nurses' occupational exposure and experience of death and the impact of these experiences on nurses and patient care. The overriding commitment to capturing the individual's experience or exposure to an emotionally laden phenomenon also warranted a qualitative approach (Parahoo, 2006). Articles were rejected if they were found to be editorial letters, commentaries, literature reviews, or reporting a quantitative study. The procedure of managing the pool of 152 articles is outlined in figure 1.

Review Process

The two investigators completed an initial review of all article titles for relevance to the subject of occupational exposure and experience of death and its impact on nurses. Occupational exposure and experience of death was defined as working in an environment where one regularly directly cares for dying or deceased persons and their relatives or significant others (Keene, Hutton, Hall & Rushton, 2010; Mercer & Feeney, 2009). The impact of occupational exposure and experience of death was conceived as the consequences such as emotional, behavioural, physical, cognitive, or spiritual distress and the associated outcomes (Maloney & Chaiken, 1999). If one of the two investigators decided that an article title was possibly relevant, the abstract was recovered and reviewed. The abstracts were screened by the two investigators, and if both agreed on the inclusion status, they independently read the article to abstract data on exposure or experiences, impact or outcomes. When there was dissimilarity regarding the abstract, a third reviewer was assigned to break the tie. Abstract reviewers were blinded to comments of the other reviewers. All the articles were reviewed by both the authors.

Table 1: Qualitative Studies focusing on outcomes of occupational exposure to patient death and death situations by nurses

Author	Participants (N)	Design, Methods and Instrument	Study Purpose	Key findings and conclusion
Costello, 2006	29 Nurses	• In-depth interview • Interview schedule	To explore hospital nurses' experience of patient death and dying.	• The different experiences of death were based on the extent to which nurses were able to exert control over the dying process. • Good and bad death focused less on patients' needs and dying process and more on the death event and nurses' ability to manage organizational demands. • Study did not specify emotional and physical outcomes/response to death
Boroujeni et al, 2008	18 Nurses	• Grounded theory • Semi-structured interviews • Interview guide	To explore the nurse-patient interaction in terminally ill situations in acute care, focusing on the nurses preparation for loss.	• When nurses became too close to their patients, they were more affected by the patients' death. • Nurses used distancing to protect themselves from the pain of severe grief after patients death and also to be ready to help other patients with professionalism at all times.
Shorter & Stayt, 2009	8 Nurses	• Heideggerian phenomenological approach • Interviews • Interview guide	To study of critical care nurses experiences of grief and their coping mechanisms when a patient dies	• The death of patient was less traumatic if perceived to be 'good death', incorporating expectedness, control and good nursing care. • Informal conversations with colleagues were described as a means of coping. • Repeated exposure to death and grief may lead to occupational stress and ultimately burn out. • Emotional disengagement from caring for the dying may have an impact on the quality of care for both the dying patient and their family • The study did not specify emotional and physical outcomes/response to death.
Fridh et al., 2009	9 Nurses	• Explorative design • Interviews • Interview guide	To explore nurses' experiences and perceptions of caring for dying patients in an ICU, focusing on unaccompanied patients, the proximity of family members and environmental aspects.	• To meet dying patients' psychological and existential needs, ICU nurses need psychological support and education about how to communicate with dying patients.
Peterson et al., 2010	15 Nurses	• Grounded theory approach • In-depth interviews, online open-ended surveys • Interview schedule	To examine the resources that nurses use when coping with the death of a patient	• Internally, nurses found that evaluating the death and relying on professional distancing helped them cope. • Externally, the nurses looked at peers, religious resources and patient's families for comfort. • Families provided support and comfort to the health provider when the patient died. • Study did not specify emotional and physical outcomes/response to death
Gerow et al., 2010	11 Nurses	• Phenomenological design, • Semi-structured interviews and • Semi-structured interview guide	To describe the live experience of nurses surrounding the death of their patient.	• The emotional response to the death of a patient depends on the connection the nurse formed while caring for the patient. • Significant death experience early in a nurse's career set the foundation for how the nurse began caring for future dying patients. • Nurse's view of death experience formed the patient death perspective and shaped the way they coped and responded. • Nurses created a curtain of protection to mitigate the grieving process and allow them to continue to provide support and nursing care.

Author	Participants (N)	Design, Methods and Instrument	Study Purpose	Key findings and conclusion
Yu & Chan, 2010	12 Nurses	• In-depth interview • Interview guide • Interview guide	To describe ICU nurses response to the death of patients ad explores their perceived factors that influenced the care offered to dying patients	• Emotional reactions to patient's death ranged from disbelief, sadness, helplessness to loss and guilt. • Coping with dying was through distancing, seeking support, fatalism and commitment to care. • Nurses regarded support and sharing with their peers as an effective way of helping them to unload their feelings. • No difference between the response to death of experienced and less experienced nurses.
Iranmanesh et al., 2010 Reference	16 Nurses	• Phenomenological approach • Interviews	To describe the meaning of nurses' experience of caring the dying people in the cultural context of Iran and Sweden.	• Being with dying people raised an ethical demand that called for personal and professional response, regardless of sex, culture, or context. • Organizations should support nurses to stand up to the demands of dying patients and their families. • Teamwork, religion and a balance between patient closeness and distance are good coping strategies for nurses providing care to dying patients.
Bailey et al., 2011	10 Nurses	• Ethnographic methods • In-depth and semi-structured interviews • Interview guide	To explore how emergency nurses manage the emotional impact of death and dying in emergency work	• Nurses who invest their therapeutic self into the nurse-patient relationship and can manage emotional labour can develop an emotional intelligence in caring for the dying and bereaved. • Despite the emotional impact, they found reward in caring for the dying and their relatives ultimately creating a more positive experience for both the patient and the nurse. • Barriers that prevent the transition in the investment of the self in the nurse-patient relationship, management of emotion labour and development of emotional intelligence contribute to occupational stress and can lead to burnout and withdraw from practice.
Wenzel et al., 2011	34 Nurses	• Descriptive qualitative approach • Focus group discussions • Focus group discussion guide	To determine facilitators and barriers to managing patients loss from the combined perspective of oncology nurses and to extract essential components of supportive intervention	• Creating a supportive environment for patients and their families can improve job satisfaction and decrease compassion fatigue. • Nurses can cope better with patients loss if they are well supported during patients death by working through the bereavement process
Hinderer 2012	Nurses	• Phenomenological descriptive design • Interviews • Interview guide	To explore critical care nurses experiences with patient death	• Nurses' experiences with patients' death caused personal distress, emotional disconnections; coping strategies were evoked and inevitable death. • Understanding critical care nurses' reactions to patient death may help to improve the care provided to critically ill dying patients and their families and to meet the needs of the nurses who care for them.
Rejno et al., 2012	19 Nurses	• Focus group interviews • Focus group discussion guide	To describe ethical problems in the face of sudden and unexpected death.	• Ethical problems were more likely to arise when the period of care was longer. • Mutual trust both within the health care team and between the family members could be seen as a way of handling ethical problems. • Main ethical problems were giving information when condition was unstable, deciding on care when situation is changing and support when uncertainty prevails
Bloomer et al, 2013	12 Nurses	• Explorative, descriptive study • Focus group discussion • Focus group discussion guides	To explore the nurses' perspective on their preparedness and ability to provide their care for the family.	• They provided individualized care to meet the family's needs for information, education, emotional support, and comfort. • Nurses experienced feelings of inadequacy and under-preparedness to deal with the grief and devastation they witnessed families go through. • Educational preparation did not extend to caring for the dying patients and their families.

Thirteen (13) articles met the inclusion criteria. The findings from the reports were used to generate a synthesis table (see Table 1) summarizing descriptively the qualitative results (Voils, Sandelowski, Barroso & Hasselblad, 2008). The data extracted from the articles include author(s), year of publication, and number of participants, methods, purpose, main findings, and conclusions. The results were extracted regardless of the respective studies sample size, as this meets the qualitative research importance of taking into account of all data no matter how distinctive (Voils et al., 2008). The findings of the qualitative studies focusing on nurses' occupational exposure and experience of death were interpreted together to create new understanding by comparing and analysing concepts and results from individual studies (Higgins & Green, 2011; Voils et al., 2008). Similar findings were then grouped into categories, which were later edited to make concise but complete statements as shown in the results.

Results

The findings from the studies reviewed (table 1) show that nurses' respond to and affected by occupational exposure and experience of death in different ways depending on their perspectives about specific death. However, sudden death experiences tend to evoke intense emotional reactions such as sadness, guilt, and shock than if the death is expected. The impact of occupational exposure and experience of death on nurses also depends on the bond between the nurse and the patient, perceptions about a patient death as "good" or "bad" and the extent to which the nurse can exert control over the dying process. Following a confined analysis of the studies, three broad themes reliably emerged: positive impact, negative impact and coping with occupational exposure and experience of death. The findings from the majority of the 13 studies show that occupational exposure and understanding of death sometimes has a positive effect on nurses. The impact was appraised to be positive because it enhanced some aspects of nursing practice. The positive impact was summarized under sub-themes such as bonding with deceased patient's family; professionalism; devotion to patient care; self-confidence; teamwork; ability to handle ethical problems and emphasis on individualized patient care (including relatives of the patient). The positive impact was mostly experienced when nurses perceived the death as "good" or when they used effective methods and resources to cope with occupational exposure and experience of death.

The adverse effects of occupational exposure and experience of death were interpreted to be both short term and long term. The short term or immediate negative impact of occupational exposure and experience of death was mainly emotional reactions such as fear, stress, sadness, severe grief, perceived traumatic experience, and self-doubt. It seems that occupational exposure and experience of death among nurses with ineffective ways coping or resources may later on lead to negative consequences. The short-term adverse outcomes may aggregate into long term effects that in our analysis were grouped under the sub-themes of occupational stress; compassionate fatigue; burnout; and withdrawal from clinical practice.

To continue doing their job and expected roles, the nurses find ways of coping with occupational exposure and experience of death. The findings of the 13 studies show that nurses adopted a mixture of coping strategies some of which may be efficient and others ineffective. Under the theme of dealing with occupational exposure and experience of death, the sub-theme of ineffective coping was generated with examples such as professional distancing and avoidance to think, avoiding to use available organizational support resources and discuss the occupational exposure and experience of death. The sub-theme of active coping was exemplified by methods such as informal conversation with colleagues and friends, seeking support from religious resources, acceptance, and seeking comfort from deceased patients' family members. Grief support was given in the form of open dialogue among newly trained and more experienced health workers and psychological support.

Discussion

Coping with patient death is stressful and to continue working in their profession, nurses need to use effective strategies to deal with regular occupational exposure and experience of death (Peterson et al., 2010; Hinderer, 2012). The deaths nurses experience sometimes shapes the ways they use to cope and respond to other death and associated situations (Gerow et al., 2010). Howerever most

nurses encountering patient death experiences at the work place do not comprehend their need to grieve (Borsche, 2007), instead they utilize coping mechanisms such as suppression, distancing, trying to keep busy and avoidance (Bailey, Murphy & Porock, 2011; Huang, Chang, Sun & Ma, 2010; Kent, Anderson & Owens, 2012). Distancing and avoidance is mostly common among nurses working in cultures where emotions are not expressed openly and these strategies serve as a shield from confronting their vulnerability and distressing emotions elicited by patient death and death situations (Yu & Chan, 2010).

The other strategies used by nurses to cope with occupational exposure and experience of death were seeking support from peers with whom they can discuss the death experience, crying in front of family members of the patient, seeking support from religious resources and prayer (Gerow et al., 2010; Peterson et al., 2010; Sinclair, 2011). Literature about coping with other types of stressors define ways of coping such as distancing, avoidance, selective concetration, blaming, minimalizing, wishful thinking, venting emotions, distracting activities (alcohol or drugs), seeking social support, exercising and meditating as emotion-focused strategies (Folkman & Moskowitz, 2004). The majority of the studies reviewed reported that nurses were using strategies that can be categorized as emotion-focused coping strategies to cope with occupational exposure and experience of death. Although emotion-focused coping can be beneficial in situations where there are few options, it is often associated with more adverse outcomes (Werner, 2006). Therefore, employers of nurses need to increase options for coping with occupational exposure and experience of death such as mandatory respite time, time for grieving and debriefing, because they provide nurses with opportunities to address directly the emotions and distress elicited by patient death or death situation.

Gerow and Collegues (2010) reported that some nurses used caring rituals such as going for funerals, giving food, facial tissues and drinks to the family members to help provide them with security, orderliness and control in the middle of the emotional disorder. The activities helped nurses to detach themselves from the occupational exposure and experience of death and to get some closure.

Other nurses used fatalism perspective to approach occupational exposure and experience of death, by choosing to think of life and death as fate that they could not regulate and this helped in reducing self-blame (Wong & Chan, 2007; Yu & Chan, 2010). The later ways of coping are similar to problem-focused coping. Problem-focused coping involves approaches directed at handling the problem triggering the distress and this category of coping is associated with positive healthy consequences and general wellness (Kelso, French & Fernandez, 2005; Lazarus & Folkman, 1984). The other examples of problem-focused coping strategies include; directing efforts to behaviorally handle difficult situations; collecting information; decision-making; resolving conflicts; acquiring resources; and situation specific goals or task oriented actions (Matthieu & Ivanoff, 2006). The benefits of problem-focused coping strategies and over-use of emotion-focused coping by nurses, when faced with occupational exposure and experience of death, seem to suggest that deliberate education, training, coaching, and mentoring can be of benefit. Nurse educators and employers can play a central role in integrating these strategies in their services because they empower nurses to cope and adapt to occupational exposure and experience of death.

Failure to deal with occupational exposure and experience of death is not an option because its impact on nurses and the patients they care for in future is significant. The short-term adverse outcomes of occupational exposure and experience of death include emotional symptoms such as feeling sad, fatigue, sleep disturbance, fear, guilt, sorrow, restlessness and others (Chen & Hu, 2013; Peterson et al., 2010; Wilson & Kirshbaum, 2011). The emotional reactions are more intense in situations involving a "bad death" (Loiselle & Sterling, 2011; Zambrano & Barton, 2011). Moreover, the literature shows that "bad death" experiences are associated with staff shortage and severe distress among nurses and other healthcare professionals (Costello, 2006; Shorter & Stayt, 2009; Parry, 2011). On the other hand, when nurses perceive the death as a "good death" they are less negatively impacted. But the nurses' idea of good death focuses on the death occurrence rather than the dying process (Bryan, 2007), hence the view that "good death" involves a lack of distress and suffering whereas "bad

death" involves a crisis for dying people and causes "trauma" to patients, families and caregivers (Kehl, 2006; Shorter & Stayt, 2009).

Death education, training, coaching and mentoring are effective interventions that can help in addressing the stress curtailing from occupational exposure and experience of death (Gerow et al., 2010; Huang et al., 2009; Mok, Lee & Wong, 2002). When nurses are confronted with patient death and death situations, they are expected to provide support for patients, families and help maintain the emotional well-being of all involved (Mok et al., 2002). This is only possible if nurses are well educated, trained, coached and mentored in matters of death and dying to empower them to communicate bad news, cope with patient death, provide optimal care for dying patients and their relatives without significant detriment to their own well-being (Gerow et al., 2010; Huang et al., 2010; Mok et al., 2002; Parry, 2011). Many nurses have not had training or education focusing on death and dying or end of life issues and as a result they cope with this situation using past death experiences (Bloomer et al., 2013; Gerow et al., 2010; Peterson et al., 2010). Nurses who are supported, mentored and coached during past death experiences can learn and emotionally cope with the death, and this provides a healthy basis for future experiences (Gerow et al., 2010; Huang et al., 2010).

Nurses, who are not supported and mentored may experience adverse outcomes that could cascade into mental and physical ill health (Gerow et al., 2010; Parry, 2011). Moreover, a sustained experience of the mental and physical impact of occupational exposure and experience of death affects nurses' professional quality of life. There is need for deliberate strategies by nurse educators and employers to address nurses' occupational exposure and experience of death because literature shows that nurses who receive training in palliative care skills, acknowledge acquiring necessary skills to support relatives when a family member dies (Moores, Castle, Shaw, Stockton & Bennett, 2007). Additional research and other efforts are needed to identify the most effective intervention to address the impact of occupational exposure and experience of death on nurses and effective personal coping strategies. The specific areas that need to be paid attention to

apart from the effects of occupational exposure and experience of death, include the best approaches to communicating death news, moderating factors, and coping with patient death especially where contact with the patient and the family members was brief and without an ongoing professional relationship. Such inquiries on the phenomenon of occupational exposure and experience of death will demarcate the challenge for nurse educators, employers, and other researchers. Moreover, they will make the ultimate goal of maintaining quality nursing care and nurses' professional quality of life achievable.

Conclusion

Nurses are exposed and experience patient death or death situations regularly and play a significant role in supporting and caring for patients and their families during death and dying. Although occupational exposure and experience of patient death and death situation (occupational exposure and experience of death) may be a source of positive outcomes among nurses with effective ways of coping, it can also have severe negative impact on patient care and the nurses' professional quality of life. The shorter and long-term adverse outcomes of occupational exposure and experience of death can be curtailed if the nurses are supported and provided with deliberate knowledge, skills and other training to manage and handle patient death and death situations. Employers can also play a role in curtailing the negative impact of occupational exposure and experience of death, and this can be through policies and providing resources that encourage positive grieving approaches, adequate debriefing, and respite. However to emphatically understand the extent of the impact of occupational exposure and experience of death and efficient intervention to enhance its positive outcomes and curtail its adverse results, there is a need for more focused and consistent research among nurses. Therefore nurse educators, researchers, and employers have central and critical roles to play in curtailing the impact of occupational exposure and experience of death on patient care and nurses' professional quality of life.

Implications of practice

- Although occupational exposure and experience in patient death or death situations by nurses have not received enough attention and publicity,

it can severely affect professional quality of life and patient care.

- Nurses, nurse educators, researchers, and employers need to monitor and understand the impact of occupational exposure and experience during patient death or death situations on patient care and professional quality of life.
- Nurse educators, researchers and employers need to develop deliberate strategies and efficient systems to curtail the negative impact of occupational exposure and experience of patient death or death situations on patient care and nurses' professional quality of life.

Acknowledgements

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